

## IN A MOTOR VEHICLE ACCIDENT WITH RENTAL VEHICLE?

### What the driver needs to do:

#### Quick Reference Guide

1. Call the Police
  - \*If on campus call ODU Police, 683-4000
  - \*If off campus call Virginia State Police, 800-552-9965
  - \*If out of state, call local Police
2. Contact the Rental Car company
3. Contact your Advisor
4. Complete an Automobile Incident Report/Form and send to Risk Management within 24 hours of the accident
  - \* Automobile Incident Report/Form is available at the Risk Management website: <https://www.odu.edu/riskmanagement/forms>
5. Get copy of the Police Accident Report or Report Number from the responding Police Officer and Officer's name
6. Get name, address, telephone number and insurance information from other driver
  - \* Obtain from other driver the name of his/her insurance carrier & policy number
7. Take photos at the scene and/or damage vehicles, if possible



OLD DOMINION UNIVERSITY

OFFICE OF RISK MANAGEMENT, Tel. Number: 757-683-4009/Fax Number: 757-683-6025

[www.odu.edu/riskmanagement](http://www.odu.edu/riskmanagement)

THIS FORM SHOULD BE COMPLETED BY THE DRIVER.

Old Dominion University  
Auto Loss Incident Report  
FORM

PRINT

THIS FORM SHOULD ONLY BE PROVIDED TO THE OFFICE OF RISK MANAGEMENT

When an accident occurs, follow the instruction on the envelope provided in your glove compartment. Any questions should be referred to ODU's Office of Risk Management at 757-683-4009. This form should be sent to Risk Management within 24 hours of the accident. DO NOT DISCUSS ACCIDENT WITH ANYONE EXCEPT RISK MANAGEMENT, DRM, OR THE POLICE.

<b>POLICY-HOLDER</b>	NAME <b>OLD DOMINION UNIVERSITY-OFFICE OF RISK MANAGEMENT</b>					PHONE <b>757-683-4009</b>	
	ADDRESS: STREET <b>5255 Hampton Blvd., Ste 2501</b>		CITY <b>Norfolk</b>	STATE <b>VA</b>	ZIP CODE <b>23529</b>	FAX <b>757-683-6025</b>	
<b>TIME AND PLACE OF ACCIDENT</b>	DATE OF ACCIDENT	HOUR <input type="checkbox"/> AM <input type="checkbox"/> PM	STREET OR HIGHWAY		CITY	COUNTY	
	STATE		STATE				
<b>STATE AGENCY OR COMMUNITY SERVICES BOARD as Insurance USE ONLY</b>	MAKE OF AUTO	YEAR	BODY TYPE	VEHICLE IDENTIFICATION NUMBER (VIN #)	STATE VEHICLE LICENSE PLATE #		
	NAME OR OWNER OR LEASING COMPANY		ADDRESS: STREET		CITY	STATE ZIP CODE	
	NAME OF DRIVER		ADDRESS: STREET		CITY	STATE ZIP CODE	
	DRIVER'S DATE OF BIRTH	DRIVER'S LICENSE NUMBER	DRIVER CONTACT #:		WAS LICENSE IN EFFECT AT THE TIME OF ACCIDENT?		
	WAS AUTO BEING OPERATED FOR BUSINESS OR PLEASURE <input type="checkbox"/> BUSINESS <input type="checkbox"/> PLEASURE		WIND GAME PERMISSION?	WHERE WAS THE DRIVER GOING TO AND COMING FROM AT TIME OF ACCIDENT?			
	DESCRIBE PARTS DAMAGED AND EXTENT OF DAMAGE (NOTE: BY TERMS OF YOUR POLICY THE COMPANY MUST BE GIVEN REASONABLE OPPORTUNITY TO EXAMINE AUTO BEFORE REPAIRS ARE MADE OF GLASS DAMAGE, SEE SECOND PAGE)						
	WHERE MAY AUTO BE SEEN?		ESTIMATED COST OF REPAIRS		WHERE IS THE VEHICLE NORMALLY GARAGED? (CITY & STATE)		
<b>OTHER AUTO INVOLVED</b>	MAKE OF AUTO	YEAR	LICENSE NUMBER	ESTIMATED COST OF REPAIRS			
	PARTS DAMAGED AND EXTENT OF DAMAGE						
	NAME OF OWNER		ADDRESS: STREET		CITY	STATE ZIP CODE	
	NAME OF DRIVER		ADDRESS: STREET		CITY	STATE ZIP CODE	
	IS AUTO INSURED? <input type="checkbox"/> YES <input type="checkbox"/> NO		NAME OF INSURANCE COMPANY				
<b>PASSENGERS</b>	NAMES OF PASSENGERS IN YOUR AUTO		ADDRESSES: STREET		CITY	STATE ZIP CODE	
	NAMES OF PASSENGERS IN OTHER AUTO		ADDRESSES: STREET		CITY	STATE ZIP CODE	
	NAMES OF PERSON INJURED		ADDRESSES:		INJURIES	AGE	
	IN WHICH AUTO WERE INJURED INDICED?						
<b>INJURIES (No Matter How Minor)</b>	NAME OF DOCTOR OR HOSPITAL		ADDRESS: STREET		CITY	STATE ZIP CODE	

**CONFIDENTIAL: CLAIM INVESTIGATIVE MATERIALS**

<b>Property Damage Other than Auto</b>	Name of owner		Address		Street	City	State	Zip Code	
	Kind of property								
	Estimated cost of repair			Where may property be seen?					
<b>Witnesses</b>	Names / phone numbers		Addresses		Street	City	State	Zip Code	
<b>Description of Accident</b>	On what street were you driving?		Direction	Speed	Street or road other auto was driving on		Direction	Speed	
	Were your lights on?		Were the other auto's lights on?		Traffic controls in place?	For whom?	Speed Limit		
	Y <input type="checkbox"/>	Bright <input type="checkbox"/> Dim <input type="checkbox"/>	Y <input type="checkbox"/>	Bright <input type="checkbox"/> Dim <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	N <input type="checkbox"/>		N <input type="checkbox"/>						
	Did either driver give signal of any kind?		If intersection who entered first?		Who had right of way?				
	Y <input type="checkbox"/>	If yes, who?							
	N <input type="checkbox"/>								
	Describe how the accident happened. Include any special details of the collision. Attach additional sheets if needed.								
	Show on the diagram the position of all autos, persons, traffic controls (stop lights, stop signs, etc.) and other objects. Show street names.								
<b>Your Auto's Glass Breakage</b>	Type of glass:	Tinted <input type="checkbox"/>	Safety <input type="checkbox"/>	Type of break:	Cracked <input type="checkbox"/>	Chipped or pitted <input type="checkbox"/>			
		Clear <input type="checkbox"/>	Plate <input type="checkbox"/>		Shattered <input type="checkbox"/>	Bull's eye <input type="checkbox"/>	Half moon <input type="checkbox"/>		
	Location of breakage:	Vent <input type="checkbox"/>	Recall <input type="checkbox"/>	Door <input type="checkbox"/>	Other (describe)				
	Windshield	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
Windshield damage: check "Type of glass" and "Type of break", above, and mark location on diagram									
Do you think a claim will be made against you?			By whom?						
Y <input type="checkbox"/>	Uncertain <input type="checkbox"/>								
N <input type="checkbox"/>	<input type="checkbox"/>								
Your Name Printed			Your signature						
What is your title / position in organization?			Date						
Your phone number			Your email address						
NOTE: When submitting this form electronically, your initials below will serve as your electronic signature.									
Reported to (Name)		Initials	Reported by (Name)		Initials	Date reported			

**NEITHER SUBMITTED NOR ACCEPTED AS NOTICE IN SATISFACTION OF ANY FILING REQUIREMENTS**